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Workplace Health and Safety Concerns in Service Organizations in the Inner City

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ABSTRACT *There is little known about occupational health and safety concerns or programs in workplaces in the inner city. This work was part of a needs assessment for development of occupational health and safety programs for workplaces in the inner city. Its key objective was to identify inner-city worker concerns regarding specific hazards. The work involved two phases. The first sampled workers in an inner-city hospital and church, and the second involved both paid and volunteer workers in inner-city community outreach programs. The key concerns raised by inner-city workers were infectious disease and personal safety and violence. Occupational health and safety programs need to address infectious disease and personal safety issues in this environment. Further research is needed regarding workplace health and safety in inner-city workplaces, both regarding hazards particular to the inner city and occupational health programs for the workers, both paid and volunteer, who work there.*

KEYWORDS *Inner-city workers, Inner-city workplaces, Occupational health, Worker safety.*

INTRODUCTION

Workplace injuries and illnesses account for substantial disability. In the United States, for 2001 there were 5.2 million workplace injuries and illnesses reported by the Bureau of Labor.[1] We are interested in the occupational health and safety experience of workers and workplaces in the inner city. Within an inner city, there are often concentrations of disadvantaged populations. These populations experience a variety of health problems, including mental illness, substance use, violence, disablement, and infectious diseases such as human immunodeficiency virus (HIV) and tuberculosis. Because of this concentration of marginalized individuals, there are a number of organizations that provide assistance to them. These may include health care, public social service, religious, and not-for-profit, charitable organizations.

These inner-city service organizations may have a more hazardous work environment in comparison to other organizations. Factors leading to the increased risk may be the clients themselves (because of their various health problems), the stresses of a small, nonprofit organization (NPO), and the potential conflict between service to the client and safety of the staff. Further, in spite of the increased risks, these small organizations may have limited administrative and financial resources and

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therefore may not have appropriate prevention programs in place. Workers in these organizations are also exposed to the hazards of living and working in an urban environment.

There is little information available regarding occupational health and safety in the inner city. Possible issues are identified in the literature on workplace violence and infectious disease, particularly in the health care setting. In addition, literature dealing with small business and the nonprofit sector provides some insight. These sources suggest that violence and infectious disease may be a particular concern in the inner city setting with a high concentration of homeless individuals and the social service organizations, often small and nonprofit, that provide service to the homeless.

The purpose of this needs assessment was to identify workers' perceptions of occupational hazards in the inner-city environment.

METHODS

There were two phases to this needs assessment work. The first phase of the study involved a comparison of worker perceptions regarding workplace hazards in two neighboring institutions in the inner city of metropolitan Toronto, Ontario, Canada. The second phase was an extension of the survey to paid and volunteer workers who attended a workshop on prevention of injuries and illness in outreach settings.

Hospital–Church Comparison Study

St. Michael's Hospital (SMH) and Metropolitan United Church (MUC) have occupied contiguous blocks in the inner city of Toronto for over 110 years. Among the populations served by both organizations are inner-city inhabitants, including the homeless.

SMH was established in 1892 to care for the sick and the poor of Toronto's inner city. It is an academic teaching hospital with multiple outreach sites providing a variety of health care services. It has approximately 4,600 employees, 600 physicians, 1,000 students, and 500 volunteers.

MUC, established in 1818 has been on its present site since 1872. It has a dual mission to strengthen members' faith and to minister to all who seek physical, emotional, and spiritual assistance, with a focus on the downtown marginalized population. Church programs include an on-site hostel for 50 men, refugee accommodation for 40, and drop-in center with food, clothing, and housing assistance and skill development programs. It has a staff of approximately 30, the majority of whom work a few hours per week, and 300 volunteers.

All of the paid employees of MUC were identified and classified based on age group (<30 years, 30–50 years, >50 years), sex, and general job class (professional, administrative, support). Casual workers who are paid an honorarium were not included. A convenience sample of employees of the Inner City Health Program of SMH was selected.

The questionnaire was administered by one of two interviewers (D. L. H. or S. S.) over the summer of 2002. It was conducted as part of a needs assessment process for the occupational health and safety programs of the two institutions. The main focus of the survey was the respondent's perception of work in the inner city and hazards in his or her workplace. Initially, an open question was posed asking the respondent to identify his or her three major occupational health and safety

concerns, and then a directed question asked the person to rate his or her level of concern regarding the following workplace hazards: chemical, noise and vibration, indoor air quality, radiation, infectious disease, safety related to equipment, safety related to violence, stress, and ergonomic problems. A 3-point rating scale was used: "no concern," "some concern," and "a lot of concern." The results were tabulated and analyzed using SAS.[2] Simple descriptive statistics were calculated.

Survey of Workshop Attendees

An opportunity arose to extend the sampling to individuals who were attending a workshop, Caring with Compassion, organized by the Canadian Association of Church Management for those who were in contact with the disadvantaged in various social service settings, primarily church-based programs such as meal programs or drop-in centers. The identical questions regarding potential workplace hazards were used. The questionnaire was self-administered. The results were tabulated and analyzed using SAS. Simple descriptive statistics were calculated.

RESULTS

Hospital–Church Comparison Study

There were 36 workers who participated, 18 from each institution; 67% were male, and 38% were older than 50 years. There were 50% classified as professional staff, 17% as administrative staff, and 33% as support staff. Of participants, 27% had been at their current workplace for longer than 10 years.

The majority of workers at both SMH and MUC knew about the outreach mission of the organization at the time of hire and stated it had a positive effect on their decision regarding employment. Approximately 50% thought an urban workplace was inherently more hazardous than a suburban one, more so of the church staff.

The responses to the open-ended question are presented in Table 1. For both SMH and MUC workers, the majority noted infectious disease as a key concern (SMH 67%, MUC 56%) in response to the open ended question. Hospital staff also noted ergonomic (28%) and personal safety (22%) issues. The most prevalent concern of church staff was personal safety (61%), which was significantly different from the response of the hospital staff. Two church staff also raised a concern about fire.

The responses to the directed questions are also presented in Table 1. For comparison with the open-ended question, the responses of some concern and a lot of concern are grouped together as the affirmative response to produce a dichotomous yes/no response. Infectious disease issues continued to be a concern for both groups. However, other hazards not identified in the open-ended question were also commonly noted as a concern. For the hospital staff, these included safety related to equipment, indoor air quality, and stress; for the church staff, indoor air quality and stress were identified. Significant differences between the two organizations were greater concern regarding personal safety in the church staff (78% vs. 39%, respectively) and greater concern regarding equipment-related safety in the hospital workers (72% vs. 33%, respectively).

Analysis of those who did and did not think the urban workplace was more hazardous identified an association between the view that the urban workplace was more hazardous and a greater likelihood of reporting concerns about infectious disease and personal safety concerns.

TABLE 1. Results of open-ended and directed questions on perception of workplace hazard, percentage reporting

	St. Michael's Hospital (N = 18)		Metropolitan United Church (N = 18)	
	Open-ended question	Directed question	Open-ended question	Directed question
Chemicals	0	39	0	33
Noise, vibration	0	44	0	22
Indoor air quality	6	61	6	83
Radiation	0	17	0	6
Infectious disease	67	83	56	78
Safety, equipment	11	72	11	33
Safety, violence	22	39	61	78
Stress	6	61	6	50
Ergonomic	28	61	17	39

Survey of Workshop Attendees

There were 51 individuals who attended the workshop; 44 attendees (86%) completed the survey, but only 37 (73%) provided complete responses. Four additional attendees worked in a suburban setting and were excluded from the analysis. The demographic characteristics of the workshop attendees were similar to those of the hospital and church staff. There were 48% males, and 52% were older than 50 years. Volunteers made up 23%, and many of the paid workers also did volunteer work in the inner city as well.

The responses to the open and directed questions are presented in Table 2. The key issues identified in the open-ended question were infectious disease and violence. There was a high proportion of individuals in this group reporting concerns to all of the hazards on the directed questions.

In general, the workshop attendees reported they had a lot of concern about the various hazards compared to the SMH or MUC workers. Personal safety and stress were particularly of more concern for the workshop attendees.

TABLE 2. Results of open-ended and directed questions on perception of workplace hazard for workshop attendees, percentage reporting (N = 31)

	Open ended question	Directed question
Chemicals	0	65
Noise, vibration	0	74
Indoor air quality	0	84
Radiation	0	42
Infectious disease	65	94
Safety, equipment	0	74
Safety, violence	71	100
Stress	16	97
Ergonomic	6	77

DISCUSSION

The key concerns identified by the church and workshop attendees were infectious disease and personal safety or violence. There was also an association between the view that urban/inner-city workplaces were more hazardous than suburban sites and reporting concerns related to infectious disease and violence.

The study's findings are in keeping with previously reported health hazards in health care and social service workers. There is information about workplace violence and assaults in health care and social services agencies, and some of this work has been carried out in inner-city settings. However, the aim of the studies reviewed was not to address inner-city concerns specifically. High rates of workplace assaults have been documented, and underreporting of incidents is commonly noted.[3–5] In the health care setting, risk factors for assaults included an organizational culture that accepted assaults as part of job, inner-city locale, patients with mental illness or substance use, lack of security, and financial constraint leading to decreased staffing and long wait times.[6,7] In some of these workplaces, an emphasis on customer satisfaction created stress in workers, and the need to be customer friendly reduced a visible security presence. Public/social service organizations have noted underreporting of assaults.[8,9] Risk of violence increased with homeless clients and work involving field or home visits.[10,11] Ungvarski reported on a home care program for HIV/AIDS (acquired immunodeficiency syndrome) in New York and found violence a concern in areas with high crime and substance use.[12] The significant difference in concern between the hospital and church staff probably relates in part to the presence of visible security staff 24 hours a day in the hospital.

There is some information in the literature regarding infectious disease risks in inner-city workplaces. Two types of infectious disease are of concern: tuberculosis and blood-borne pathogens such as hepatitis B and C and HIV. Nardell discussed the challenges of tuberculosis (TB) control in several vulnerable types of health and social service settings, including shelters.[13] He noted a number of factors that increased the risk in the shelter setting. These included a higher entrance point prevalence of TB because of the increased prevalence of TB in the homeless population, increased potential for person-to-person transmission, less potential for detecting TB because of rapid turnover of residents, competing priorities of shelter workers, lack of cooperation of residents, limited medical resources, lack of potential for treatment, and environmental factors conducive to transmission, such as overcrowding.

The link between the client and worker is evident in the US Centers for Disease Control recommendations for the prevention of TB in the homeless; one of the strategies is enhanced TB surveillance of shelter and other facility staff.[14] McDiarmid and colleagues evaluated TB control program compliance at several different types of facilities, including shelters.[15] They found shelters were the least compliant with elements of a control program, including engineering controls, use of personal protective equipment, written program, education, isolation, 6-month tuberculin testing, and recording of conversions in the Occupational Health and Safety Administration log. This suggests that TB risk is higher in this environment, and the perception of this risk was confirmed in all of the groups we studied (hospital, church, and workshop participants).

There has been some work regarding incidents of exposure and compliance with universal precautions for blood-borne pathogens. Several studies have noted underreporting of incidents in the hospital setting.[16–19] Factors associated with the occurrence of incidents or lack of compliance with universal precautions in the

hospital setting included low commitment among senior management and a lack of safety feedback and training, lack of cleanliness of the surroundings, underuse of protective equipment in trauma cases, lack of time, interference with technical skills, perceived low-risk patients, reduced staffing, and poor organizational climate.[16,17,19,20] These diseases were also a concern in the groups studied.

The other source of information relates to workplace health and safety in small business and the nonprofit sector. Information from these sources might reasonably be thought to apply in the inner-city setting as well; however, whether the risks are magnified in the inner-city setting is not known. Nonprofit social service organizations play an important role in the inner city as they directly interface with homeless and marginalized clients, providing temporary shelter and nutrition and health services and social support programs.

A recent Canadian study found that the vast majority of nonprofit workplaces tend to be small, with over 85% employing fewer than 20 employees.[21] Small workplaces have higher rates of injury and illness than do larger workplaces.[22–24] There are a number of features of small workplaces, such as economic fragility and limited managerial support and financial resources, that play a role in exposure to risk and challenge occupational health and safety management and prevention.[25–27] Smaller workplaces also employ a disproportionate number of workers considered "at risk" because of their lack of experience, knowledge, and vulnerability in the labor market, such as young workers, immigrants, and unorganized workers.[28] A major constraint on efforts to address health and safety issues is the lack of organized points of contact or system of leadership and representation for reaching either employers or workers. Recent trends in the restructuring of work and labor markets has led to an increase in parttime employment and subcontracted and casualized work, particularly in the small business sector, which in turn has complicated the management of occupational health and safety.[22,29]

The recent Canadian study also documented that over 55% of NPOs that employ paid workers are found in the religious, civic, and social assistance sectors.[21] There are several defining characteristics that make NPOs unique as workplaces. In general, NPOs receive a majority of funding from government payments and grants that are vulnerable to policy changes that affect the structure and amount of funding available. NPOs tend to have unique organizational cultures that emphasize humanistic, communitarian, or advocacy values and eschew the profit motive.[30] However, NPOs are increasingly pressured to adopt a market framework that may be in direct opposition to the values that have traditionally governed their work and missions. Governments have made cuts to social spending and transferred the delivery of many social services to the nonprofit sector.[31,32] NPOs also face increasing accountability requirements as a result of changes in the structure of funding as short-term service contracts have replaced operational grants and long-term, core funding.[33]

Several workplace health issues have been noted in NPOs. One major factor affecting the quality of work in NPOs is very high workload, resulting in stress. Baines et al. reported that stringent reporting and documentation requirements that accompany funding contracts meant that workers had to do this sort of administrative work on their own time.[34] Changes in funding have resulted in hundreds of hours of unpaid overtime and very high levels of stress among employees in many NPOs.[35] Stress was noted as a concern by 50% of MUC staff and by 97% of the participants in the workshop, suggesting that stress is perceived as a problem in this sector in both paid and volunteer workers.

As previously noted in the hospital setting, violence also seems to be a problem for workers in NPOs. Baines et al. reported that workers in all the agencies in their study experienced frequent incidences of violence, particularly directed at female employees, who make up the majority of workers in this sector.[34] Denton and colleagues also reported violence was a major issues for home care workers.[36] In particular, small NPOs may lack the resources and supports available in larger, more established organizations (e.g., in hospitals).

Violence may present a particularly complicated problem for NPOs.[37] Workers dealing with violent clients may experience a great deal of moral distress.[36] Decisions about how to deal with violence are complicated by attachments to clients, the normalization of violence, and lack of other resources for offenders. If workers feel responsible for the well-being of high-need clients, they may risk their health by working in violent situations rather than pressing criminal charges or sending a client away. Violence was a key concern of MUC staff, with 78% noting it on questioning, and all the workshop participants noted concerns with violence. However, in contrast, the hospital staff were not as concerned about violence, with only 39% noting it on direct questioning, probably related to the presence of security staff in the hospital setting. The hospital has substantial occupational health and safety resources in place, both occupational health and safety professionals and its own security staff, who provide visible 24-hour-a-day security.

There is some indication that the physical work environment, especially in small NPOs, is particularly poor. Roberts,[37] for example, provided a graphic picture of small NPOs:

> Agencies are housed in church basements, community service centers, upstairs in small office buildings, donated rooms and refurbished houses. While most are equipped with computer equipment, the machines are frequently aging hand-me-downs. Their furniture is a mix of second-hand donations, government castoffs, and discount equipment.

Safe, ergonomically correct equipment seems unlikely in such an environment. Of church staff, 33% had equipment safety concerns, and 39% had ergonomic concerns; again, 74% of the workshop participants had equipment safety concerns, and 77% had ergonomic concerns, suggesting that this description is reflective of at least some of the NPO organizations in the inner-city environment. A high portion of the hospital staff also had concerns, but they differed in that they tended to be related to complex medical and scientific equipment and patient transfers.

CONCLUSIONS

There is a concentration of small, nonprofit social service agencies in the inner city to serve marginalized populations. There is evidence that social service workers are at greater risk for injury and disease, but little information is available to define these risks. Our needs assessment has confirmed that infectious disease and violence are key perceived risks in workers, both paid and volunteer, in inner-city social service agencies. There is minimal information available concerning occupational health and safety programs and activities and the social, organizational, job, and personal factors that influence workplace health and safety in these organizations. In particular, we lack knowledge on the nature of and significance for occupational health and safety of workplaces characterized by nonprofit organizational status,

voluntary labor, human service work, and charitable orientation. Further research to address occupational health and safety issues in inner-city workplaces is needed.

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